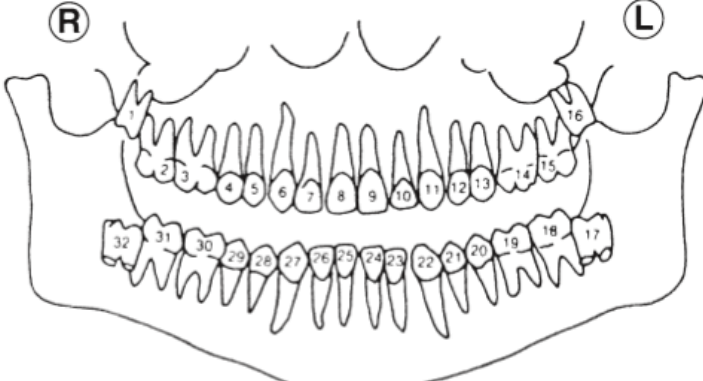


REENTRY (REPS) DENTAL SERVICE REQUEST FORM

Email: CDCRCCHCSREPSDental@CDCR.ca.gov

<input type="checkbox"/> MCRP <input type="checkbox"/> FCRP <input type="checkbox"/> OTHER:		
Service is: <input type="checkbox"/> NON-URGENT <input type="checkbox"/> URGENT ABUSE OF URGENT PA STATUS WILL BE MONITORED. Urgent requests MUST be reserved for requests that are potentially life threatening or pose a significant risk to the continuous care of the patient, in the provider's best professional judgment. Services for urgent requests must be provided within 14 days of signing request. CCHCS reserves judgment of urgency and must meet definition above, therefore, please explain reason for urgency below.		Date:
Patient Name: (Last, First, Middle Initial)	Date of Birth:	CDCR #:
Referral/Service Type Requested		
<input type="checkbox"/> Alveoplasty	<input type="checkbox"/> Biopsy/Lesion	<input type="checkbox"/> Cyst/Tumor
<input type="checkbox"/> Extraction	<input type="checkbox"/> Incision and Drainage	<input type="checkbox"/> Infection
<input type="checkbox"/> Tori Removal	<input type="checkbox"/> Oral/Facial Trauma	<input type="checkbox"/> Other:
Requesting Provider Information		Referring To Provider Information
Requesting Provider Name: (Last, First)		Referring To Provider Name: (Physician, mg.ipa, Facility, Agency)
Address: (No., Street, City, State, Zip)		Address: (No., Street, City, State, Zip)
Phone Number:		Phone Number:
Fax:		Fax:
Service Request Information		
Please Circle Teeth or Area to be Treated		
Comments or Concerns:		
Requesting Dentist's Signature:		Date:
CDCR/CCHCS Dental Services Review		
APPROVED	COMMENTS:	
MODIFIED		
DENIED		
CDCR ACDC Reviewer Signature:		Date:

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